

**HEALTH CARE FOR HEALTH CARE WORKERS**  
**Senior Long Term Care Division**  
**Medicaid Community Services Bureau**  
**2016 APPLICATION**

**EXPLANATION AND INSTRUCTIONS**

**Intent:** The 2015 Montana Legislature approved funding of \$4,931,064 through House Bill 2 for fiscal year 2016 to increase reimbursements to providers that deliver Medicaid personal assistance and private duty nursing services when those providers provide their direct care employees with health insurance coverage that meets defined criteria (providers). The next round of funding is available beginning January 1, 2016 for this insurance program (program). Funds must be used to cover health insurance premiums for eligible workers receiving health insurance coverage that meets the Department of Public Health and Human Services' benchmark standards and criteria.

**Health Insurance Plan Benchmarks:** The Department is not offering a health insurance plan. Rather, the state has established benchmarks that an insurance plan must meet in order to receive the health care for health care worker funds. A provider must sign an agreement that certifies the insurance plan they offer meets the benchmark standards set forth in the Department's application or that they were unable to find a plan that met the benchmark standards and are submitting an alternative plan with the necessary written justification outlined in section 3. A plan is not approved until the Department provides written notification of approval to the provider.

**Worker Eligibility:** Each provider will define the eligibility criteria for the number of hours a worker must work to receive insurance coverage. The Department will define eligibility as it pertains to the type of worker who is eligible to receive the health care for health care worker funding. The Department will only provide the funds for workers who work a majority of their time in Medicaid personal assistance or Medicaid private duty nursing services. The Department has established two sets of criteria to determine eligibility criteria for reimbursement. The first is for non-variable workers and the second is for variable workers. **Non-Variable Workers:** The Department will provide a 90-day grace period for eligibility for non-variable employees. If a worker is not able to meet the eligibility criteria after the 90-day grace period the provider will no longer be eligible to receive program funds to cover that worker. **Variable Workers:** The Department will provide reimbursement for workers if the worker meets the 50% threshold during employer's measurement period for the entirety of the employer's stability period. If the employee does not meet the 50% criteria during the measurement period the Department will not provide reimbursement for the worker during the stability period; regardless of the hours the worker provides in Medicaid service. Providers will be required to report on worker eligibility to remain eligible for the funding.

**Distribution Methodology:** The Department will provide a monthly gross adjustment to be used only for health insurance coverage to Medicaid enrolled personal assistance and private duty nursing providers who submit an approved application. The gross adjustment will be in addition to the Medicaid rate that is established for each provider. The amount a provider is eligible to receive is related to the portion of Medicaid personal assistance and private duty nursing units along with demonstrated utilization of the funding to enroll qualified employees in an approved health insurance plan. If a provider fails to insure the anticipated number of workers indicated on the 2016 application the provider agency will forfeit the funding allocation for those workers and the money will be used to cover eligible workers at other provider agencies. The quarterly report will provide an opportunity for the provider agency to indicate the anticipated number of enrolled members in the coming quarter. If the number is higher than the number of demonstrated enrolled workers from the previous quarter that agency must provide an explanation for the increased utilization.

**Monthly Gross Adjustment:** The actual amount of the monthly gross adjustment a provider receives is determined based on the cost of the health insurance plan that the provider pays for each enrolled worker and the number of eligible workers the provider enrolls in the health insurance plan. The final negotiated maximum monthly gross adjustment amount will be determined once a provider submits their 2016 application and subsequent quarterly utilization reports. Unused monies will be re-allocated on a quarterly basis and at the end of the fiscal year.

The monthly amount that the department determines payable to each provider will be final. The quarterly report will be used to assess program utilization and also used to determine future payments. After every quarter funding utilization will be analyzed. At this time additional funding may be made available if a provider exceeds their monthly reimbursement to cover qualified workers, however, there is no guarantee that this funding will be available. In addition, amounts paid are subject to recovery if the provider fails to maintain the required records or to spend the funds in the manner specified in the request.

**Request for Funding:** To receive Health Care for Health Care Worker funds beginning January 2016, a provider must complete the 2016 application for Department approval. The application should be submitted as soon as a provider selects an insurance plan and defines the pool of eligible workers. The 2016 application includes five sections. Section 1 contains the Certification and Agreement; Insurance Plan Agreement Form; and the Insurance Plan Eligibility and Cost Form. Section 2 is the provider's health insurance plan benchmark comparison. Section 3 is the rationale and justification statement if a provider submits a plan that does not meet all of the Department's benchmark standards. Section 4 should be completed if the provider intends to provide dental coverage through the program. Section 5 is an attached summary of the provider's insurance plan. **The application must be submitted to the Department by Friday, November 27, 2015.**

By Friday, December 4, 2015 the Department will provide written approval or disapproval to providers that submit a complete application. If the Department does not approve a request, it will return the request to the provider with a statement of the reason for disapproval. The provider will then have a limited time within which to provide justification for its proposed use of the funds. Regardless of whether the cost of a proposal approved by the Department exceeds the amount of funds payable to that provider, the Department will not reimburse the provider any more than specified in the approval letter, which will be sent out upon receipt of the application.

An electronic copy of the application material can be found on the web at:  
<http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml>

**Provider Participation:** A provider that does not submit a qualifying application for use of the funds distributed under this program as requested by the Department within the time established by the Department, or a provider that does not wish to participate in this additional funding amount, shall not be entitled to a share of the funds.

**Records and Documentation:** A provider that receives funds under this program must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including but not limited to ARM 37.40.345, 37.40.346, and 37.85.414. Reports will be requested on a semi-annual basis and as necessary. These reports will include the insurance premium monthly payment and a list of eligible covered workers.

**Fund Recovery** Recovery will occur if a provider is unable to provide health insurance coverage to the targeted number of eligible workers with a plan that meets the Department's benchmark standards or an approved alternative plan.

**Effective Date:** The Department will consider health insurance coverage beginning January 1, 2016 as meeting the legislative intent for the health care for health care worker funds.

**Reporting Requirements:** The provider shall provide documentation that these funds are used solely to provide eligible workers with a health insurance plan that has been approved by the Department. Providers must submit the application and comply with reporting requirements to meet the Department's criteria to remain eligible for these funds.

PROVIDER NAME: \_\_\_\_\_

**2016 Application- Section 1**

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**PROVIDER CERTIFICATION AND AGREEMENT**

By signing this request and in consideration for the payment of funds based upon this application, the community services provider named below ("Provider") represents and agrees as follows:

- 1. Provider certifies that statements and information included in this agreement are complete, accurate and true to the best of the undersigned provider administrator's knowledge. The Provider certifies that any funds received on the basis of this request will be used in the manner represented in this application packet to provide health insurance coverage that meets the Department’s benchmark standards for eligible personal assistance and private duty nurse workers.
- 2. Provider agrees to the terms and conditions under which this funding is made available, as stated in this application. Provider agrees that it will make, maintain and provide to authorized governmental entities and their agents, records and documentation in accordance with the requirements specified in this agreement.
- 3. Provider understands that payment of funds based upon this request will be from federal and state funds, and that any false claims, statement, or documents, or concealment of material fact, may be prosecuted under applicable federal or state laws. Provider understands that the payment made based upon this application is final, that no adjustments will be made in the payment amount to account for subsequent changes in utilization, appropriation amounts, or for any other purpose, except that amounts paid are subject to recovery in the same manner as other overpayments if the provider fails to maintain the required records or to use the funds as represented in this request.
- 4. Provider understands that the health insurance gross adjustment may not be used to offset health insurance coverage for workers who do not meet the Department’s eligibility criteria.

**Requesting Provider Identifying Information**

Provider Name: \_\_\_\_\_

Medicaid Provider #: PAS/CFC: \_\_\_\_\_ SD PAS/CFC: \_\_\_\_\_ PDN: \_\_\_\_\_

Provider Contact Name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE PLAN AGREEMENT FORM**

I, \_\_\_\_\_, representing \_\_\_\_\_  
Administrator name Provider name

have read and understand the Department’s Insurance Plan Benchmark standards and I have reviewed these benchmarks with our insurance representative. To the best of my knowledge our provider has submitted an insurance plan with this application that:

- ☐ Meets or exceeds all of the Department’s benchmark standards  
or
- ☐ Does not meet all of the Department’s benchmark standards. Our insurance carrier was unable to find a plan that meets all of the Department’s benchmark standards. Section 3 of the application includes our justification and rational for submitting an alternative plan.

Signature of Administrator: \_\_\_\_\_ Date: \_\_\_\_\_, 2015

Name of Administrator (please print): \_\_\_\_\_

**INSURANCE PLAN ELIGIBILITY AND COST INFORMATION**

1. Insurance Plan Carrier: \_\_\_\_\_

2. Insurance Plan Name: \_\_\_\_\_

3. Total monthly Premium: \_\_\_\_\_

4. Worker Monthly Premium: \_\_\_\_\_

5. Provider Monthly Premium: \_\_\_\_\_

6. Eligibility Period- Employee Category: (circle all that apply)      Full Time: \_\_\_\_\_ months  
Variable:      Measurement Period: \_\_\_\_\_ months  
Stability Period: \_\_\_\_\_ months  
Full Time-      Minimum number of hours a worker must work to qualify for insurance: \_\_\_\_\_  
Variable-      Minimum number of hours a worker must work to qualify for insurance: \_\_\_\_\_

7. Estimated number of eligible PAS/PDN workers who meet provider eligibility criteria: \_\_\_\_\_

8. Anticipated number of eligible workers who will enroll in Plan: \_\_\_\_\_

9. Monthly gross adjustment amount requested to cover health insurance premiums (line 5 x line 8) : \_\_\_\_\_

**2016 Application- Section 2**  
**HEALTH CARE FOR HEALTH CARE WORKERS**  
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Enrolled Medicaid providers will be eligible to receive additional funding for health insurance if they provide a health insurance plan that meets the following standard benchmarks. The Medicaid provider may offer either a traditional or HMO plan. The plan must include coverage for prescription drugs. Dental coverage is optional.

**Plan Approval:** The benchmark standards are indicated on the Department’s benchmark standards (see below).

- 1. If an insurance plan meets all of the benchmark standards it will be approved.
- 2. If an insurance plan does not meet all of the benchmarks it may still be submitted as an alternative plan. See section 3 for the conditions to submit an insurance plan does not meet all of the Department’s benchmark standards.

**Section 2 is the completed insurance plan benchmark summary information. All applications must include a completed summary. Please fill in the blanks with a summary of your insurance plan information.**

| Description  | 2016 Provider Plan Summary  | Provider Plan Summary |
|--|---|-----------------------|
| <b>1. Deductible Maximum</b><br><br><b>2.Out-of-Pocket Maximum</b><br><i>A plan must fall into one of the two options listed for both deductible and out-of-pocket maximums.</i> | <b>Option 1:</b><br><b>Deductible Max</b> \$1,000 individual<br>\$3,000 family<br><b>Out of Pocket</b> \$6,350 individual<br>\$12,700 family<br><br>Or<br><br><b>Option 2:</b><br><b>Deductible Max</b> \$2,000 individual<br>\$4,000 family<br><b>Out of Pocket</b> \$4,000 individual<br>\$7,000 family   |                       |
| <b>3. Coinsurance</b><br><br><b>and/or</b><br><b>4. Co-Pay</b>   | Plan plays 70%<br>Member pays 30%<br><br>\$20/visit (must include preferred provider office visits, preventive services, outpatient mental health services, chiropractic and chemical dependency services)  |                       |
| <b>5. Out-of-network coinsurance rate (applies to PPO plans)</b>   | Comply with HB544 Network Adequacy Law<br><a href="http://leg.mt.gov/bills/2013/hb0599/HB0544_2.pdf">http://leg.mt.gov/bills/2013/hb0599/HB0544_2.pdf</a>   |                       |
| <b>6.Deductible waived for following services</b>  | Preventative covered at \$0 co-pay pursuant to Affordable Care Act  |                       |
| <b>7.Preventive care</b>   | Preventative covered at \$0 co-pay pursuant to Affordable Care Act  |                       |
| <b>8.Enrollment</b>  | Premium paid in prior month for effective date on first of the following month  |                       |
| <b>9.Benefit Service List</b><br><i>Plans must include coverage for the following:</i>   | Coverage limits for transplants, DME/Medical Supplies, and essential benefits pursuant to Affordable Care Act<br>Chiropractic Services (min 10 visits per year)   |                       |
| <b>10. Licensure/Statues</b>   | Licensed in Montana (if applicable)<br>-or-<br>Meet Montana and federal legal requirements  |                       |
| <b>11. Individual Premium</b>  | No greater than \$40/month  |                       |
| <b>12. Eligibility Period: Start date for insurance coverage (includes variable workers)</b>   | Pursuant to Affordable Care Act   |                       |
| <b>13. Eligibility for Department Reimbursement for Full Time and Variable Workers</b>   | Work at least 50% of their time in Medicaid personal assistance, community first choice, or private duty nursing.<br>Non-Variable Workers: The Department will provide reimbursement during a 90-day look back period for non-variable workers.<br>Variable Workers: The Department will provide reimbursement according to the employer’s measurement and stability period. If the worker meets the 50% threshold during the measurement period the Department will provide reimbursement for that worker for the stability period. If the employee does not meet the 50% criteria during the measurement period the Department will not provide reimbursement for the worker during the stability period. |                       |

|                          |   |  |
|--------------------------|---|--|
| 14. Monthly Premium Cost | Department will reimburse a provider up to \$700 per eligible worker (not including dental) |  |
|--------------------------|---|--|

**Prescription Drug Plan**   **Note: All plans must include prescription drug coverage**

| Category   | Benchmark Level   | Provider Plan Summary |
|------------|---|-----------------------|
| Deductible | \$200/ per member per year                                    |                       |
| Coverage   | Coverage for all three kinds (generic, formulary, brand name) |                       |

**Dental Plan**

| Category                | Benchmark Level   |  |
|-------------------------|---|--|
| Deductible              | \$50/member<br>\$150/family   |  |
| Minimum Maximum benefit | \$1000 per member/ year   |  |
| Coverage                | Preventive and diagnostic 100%<br>Fillings/oral surgery 80%<br>Dentures, bridges, etc 50% |  |

**2016 Application- Section 3**  
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**Application process for plans that do not meet the Department’s benchmark criteria:**

Section 3 must be completed if the provider is submitting an insurance plan that does not meet all of the Department’s benchmark standards or if the provider is requesting reimbursement for a plan that costs more than \$700 (excluding the worker premium and dental).

Insurance plans must meet a majority of the benchmarks listed above and include prescription drug coverage. The Department will consider insurance plans that do not meet some of the other benchmark standards; however the provider must submit the following documentation in order for the plan to be considered.

- 1. **Submit a complete application with the insurance plan the provider has selected**
- 2. **Provide an alternative insurance plan that meets all of the Department’s benchmarks. Include the insurance plan’s premium quote and insurance plan summary.**
- 3. **Provide written documentation that addresses the following:**
  - a. **Explanation for why the submitted plan was selected over other plans**
  - b. **Rationale for why the benchmarks could not be met**
  - c. **Justification for how the selected plan provides accessible and affordable insurance coverage to workers**

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**Section 4**  
**Dental Coverage**

There may be additional funding available to cover the cost of dental premiums. In the line below indicate whether you plan to provide coverage or whether you are requesting additional funding to provide dental.

\_\_\_ No, our agency will not provide dental coverage to workers.

\_\_\_ Yes, our agency will provide dental coverage. We DO NOT need additional funding to provide coverage to workers.

\_\_\_ Yes, our agency will provide dental coverage. We NEED additional funding to provide coverage to workers.

**DENTAL PLAN ELIGIBILITY AND COST INFORMATION**

1. **Dental Insurance Plan Carrier:** \_\_\_\_\_
2. **Dental Insurance Plan Name:** \_\_\_\_\_
4. **Dental Monthly Premium:** \_\_\_\_\_
4. **Number of eligible workers who will enroll in Dental Plan:** \_\_\_\_\_
5. **Monthly gross adjustment amount requested to cover dental insurance premiums (line 3 x line 4) :** \_\_\_\_\_
- Note: Line 9 from section 1 + line 5 from section 4 cannot total more than the Department approved monthly allocation amount for your agency.*

**Please note that there may not be additional funding to cover dental this year**

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**Section 5**  
**Insurance Plan Submission**

**All applications must include a copy of the insurance plan summary that the agency will provide to all of the eligible workers. Be sure to include the prescription drug plan and dental plan (if applicable). Please attach the summary with this application.**

**PLEASE RETURN THE SIGNED AND DATED  
APPLICATION BY:  
Friday November 27, 2015**

**Submit Applications to:**  
**DPHHS -SLTC – Health Insurance Initiative**  
**PO Box 4210**  
**Helena MT 59604**